LISKEARD
Borough Council

THE

ANNUAL REPORT

OF THE

MEDICAL OFFICER OF HEALTH

For the Year 1950.

P. J. FOX, M.B., B.Ch., B.O.A., D.P.H.

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To the Mayor, Aldermen and Councillors of the Corporation of the Borough of Liskeard.

Your Worship, Ladies and Gentlemen,

I have the honour to present my Annual Report for the year 1950. As you are aware I hold a dual appointment, so that in addition to being Medical Officer of Health to six District Councils in South-east Cornwall I am also an Assistant County Medical Officer. In the latter capacity I represent the County Medical Officer, and am responsible for the day to day administration of certain sections of the National Health Service Act, 1946. Although District Councils have no statutory responsibility in the provision of health services under these sections of the Act, the fact that through the County precept on their rates they contribute to the cost of these services, will make them interested in the nature of the service provided. I shall therefore refer to some of these services, which in my view merit comment, and which I believe are not fully understood by members and officials of District Councils.

Dealing with health matters in all six County Districts in Health Area No. VII of the County I not un-naturally view these matters more frequently against the background of conditions in the Health Area as a whole rather than against that of the individual County District. Since social, economic, climatic and other conditions bearing on the health of the community do not vary substantially from one County District to another in Health Area No. VII, it is not surprising to find that conclusions drawn from the Area as a whole are valid for individual County Districts in that Area. For this reason, and because my work as an Assistant County Medical Officer is carried out on an Area basis, I propose to make the preface to each of my six Annual Reports a general preface, and to deal in the body of the Report with local variations from the state of affairs which obtains in the Health Area as a whole.

Health Area No. VII of Cornwall County embraces the Municipal Boroughs of Liskeard and Saltash, the Urban Districts of Looe and Torpoint, and the Rural Districts of Liskeard and St. Germans. Its total area is 164,000 acres and the total population is just over 50,000. Some 60% of the total population lives in the two Rural Districts, the remaining 40% being in the four small urban areas which make up the Health Area. There is no appreciable heavy industry in the Area, the emphasis being on agriculture. During the summer months there is a heavy influx of holiday makers to the coast which bounds the Area on the south, the chief centre of this activity being Looe. Though in theory such an influx may carry with it the risk of importing infectious disease into the Area, in practice this does not often happen. During 1950 there was some concern lest poliomyelitis, which was prevalent in many

parts of the country, particularly the midlands, might be brought to Cornwall by visitors. In fact three visitors from the Birmingham district developed the disease soon after arrival in Cornwall but in spite of the fact that the resort at which they were staying was extremely crowded, there was no extension of the disease to other visitors or the local population.

In referring to the state of health of the community in Area VII in general terms it is I think correct to say that on the whole it is up to the average of the country as a whole. Cornwall is a favourite place of retirement for those whose working days are over, and in consequence the population here contains a higher proportion of older people than the country as a whole. Knowing this, it is reasonable to expect that the death rate in Cornwall would be higher than the country as a whole, and this is what our statistics reveal. The fact that the average age at death is above that of the Country as a whole shows that the higher death rate is in this case no indictment of the state of health of the community. The birth rate is below the national average for similar reasons beyond our control. The absence of industry, with the attendant lack of employment for young people, means that numbers of people in the younger age groups leave Cornwall to work and live, and raise their families elsewhere.

Of the preventible diseases the most serious without a doubt is tuberculosis Apart from the loss of life which it causes, the chronic invalidism which accompanies it represents a serious economic loss to the Community. The period of inability to work and earn a living is measured in tuberculosis, not in days or weeks but more often in months and years. It most frequently affects persons in early adult life, thereby invaliding them at what is normally their most active and productive phase of life. Moreover because of its communicable nature its victims inevitably suffer some social ostracism, though the position here has improved somewhat, and tuberculosis no longer carries with it the social stigma it did some years ago. It would not be unreasonable to expect that heroic measures would be called for, and would be justified in dealing with such a disease. Admittedly such measures would be expensive to put into operation, at least at the outset, but properly applied they would soon have shown returns not only in reducing human suffering, but also in lessening the size of the economic burden that tuberculosis places on the community. In fact tuberculosis has been, and is still regarded with too much complacency, and with an outlook that breathes too much of despair. The prompt removal of the tuberculos patient, and his retention in a place of isolation—the sanatorium—is still in too many cases—a counsel of perfection, and so the patient remains at home, and often spreads the infection to another member of the household. We are all aware of the long waiting lists for admission to sanatoria, since from time to time articles and correspondence in the press give the matter some prominence. I do not wish to minimise the difficulties which beset those who wish and who endeavour to improve the facilities for the treatment of tuberculosis. The prime difficulty is that of providing sufficient nurses to adequately staff even the number of beds at present available, and the difficulty is correspondingly greater if regard is

given to the number of beds which would be required to fully satisfy the needs of tuberculosis. I do not believe that the inadequacy of sanatorium accommodation is any worse in Cornwall than in the country as a whole, but there is no doubt of its existence. Of the 53 cases of pulmonary tuberculosis notified during 1950 in Health Area VII only seven gained admission to Tehidy Sanatorium that year, i.e. one person in every seven suffering from tuberculosis can hope to be admitted to a sanatorium in the early stages of the disease. In spite of the difficulties associated with the provision and staffing of sanatoria, and chest clinics, I feel that a bigger proportion of the expenditure on the National Health Service should be devoted to the prevention and treatment of this chronic, crippling disease. I feel that if some of the money which has been spent on the over-lavish provision of other less-essential items in the National Health Service had been diverted to the prevention and treatment of really serious disease we should be on the right road to eradicating such scourges as tuberculosis from our midst. Viewed statistically there has been little or no change in the incidence of or mortality from tuberculosis in Health Area No. VII over the past three years, and the figures are on a par with those for the County as a whole. These statistics are given as an appendix to this report. Towards the end of 1950 a start was made on the B.C.G. vaccination scheme. This vaccine which has been extensively used on the Continent, especially in Scandinavia, has been found to stimulate in the body some resistance to tuberculous infection. At present, its use is confined to those persons who are exposed to a definite risk of contracting the disease e.g. close contacts of a case, nurses, and who have not developed any resistance to the disease. The necessity for removing suitable candidates for B.C.G. vaccination from any risk of infection for six weeks before vaccination, and six weeks after vaccination is a serious obstacle, and one which makes even more necessary the early removal to a sanatorium of cases, particularly where there are susceptible young adults and children in the household. I cannot leave the subject of tuberculosis without a reference to the importance of adequate housing in relation to this disease. One of the most important services a District Council can render to a family in which there is tuberculosis, is the provision of satisfactory housing, with adequate space, so that if at all possible the sufferer should have a separate bedroom. This measure of prevention is within the control of the District Council, when they are powerless to influence the provision of hospital accommodation, and I would therefore commend to all District Councils the claim of the tuberculosis patient on housing.

Another matter which has caused concern during the year is the inadequate provision for the care of chronic sickness occurring amongst aged and infirm persons. At the only hospital in this Area dealing with this type of case, there is invariably a long waiting list for admission. I do not wish to be critical of this state of affairs, but I feel bound to express my concern. Again much of the difficulty arises from shortage of staff—both nursing and domestic. It must be admitted that the care of aged, chronically ill people is not a very attractive career. It does not call so much for technical skill, as for a sense of devotion to the service of those unfortunate fellow-creatures, who

through the burden of years, and infirmity are unable to care for themselves. Endeavours have been made to meet the need, by providing a shorter and less technical course of training for Assistant Nurses who would form the bulk of the nursing staff in hospitals for aged and chronic sick. As far as I can gather the response from suitable young women and men has not so far been very encouraging and it would appear that this difficulty is one which will not easily be overcome. Again I feel that the care of chronic and aged sick might have received more and better consideration in the National Health Service, particularly as the proportion of older people in the community is on the increase, and there appears to be a tendency for relatives to leave their old folks to the Welfare State to be taken care of. There is some provision in the National Assistance Act whereby old and infirm persons who are adjudged by a court of summary jurisdiction as being incapable of caring for themselves can be removed to an institution or hospital on the order of the court. This piece of legislation, which is a direct interference with the liberty of the subject is one which I personally have not been called upon to certify as necessary in any case, though in at least two cases it has been given serious consideration. The fact that seven days notice of the making of this application must be given to the court and to the person managing the premises to which it is intended that the aged or infirm person should be removed, makes this the use of this section unsuitable for dealing with urgent cases.

One of the greatest triumphs of preventive medicine has been the virtual eradication of diphtheria from the community as a result of the successful immunisation campaign which has been in progress throughout the country over the past ten years. The success of this campaign can be measured by the reduction in the number of cases notified. Thus in 1940, in the County of Cornwall 392 cases of diphtheria were notified, while in 1949 the figure had fallen to three—a truly wonderful result. During the years 1948—1950 inclusive, in the whole of Health Area No. VII one case only of this disease has been notified to me. It would be a thousand pities if the valuable gains of the last decade in this sphere of public health were to be lost through apathy or groundless fears of the alleged ill-effects of immunisation on that other scourge of childhood—poliomyelitis. The absence of a disease from the community tends to breed in that community a sense of apathy towards the potential dangers and consequences of that disease. It is understandable that most young parents whose memories of the disease as it existed in their childhood have grown dim, and who know nothing of it in relation to their own or their neighbours children, should sometimes fail to realise the seriousness of the position which will arise if large numbers of the rising generation of children are not protected by immunisation. Unfortunately certain conjectures on the possible effect of recent diptheria immunisation on the incidence, and severity of paralytic poliomyelitis found their way into the popular press during 1950, and created in the minds of parents a certain amount of opposition to diptheria immunisation. There has been no clear proof that such adverse effect does in fact follow diphtheria immunisation, and in at least one recent report no such association could be found. Diphtheria has not wholly vanished from the country, and given suitable soil—a child population with an in-

creasing number of non-immunes—it will soon re-establish itself, and will again become one of the grim reapers of young lives.

Another disease which affects children and adolescents is poliomyelitis. This disease is perhaps better known as infantile paralysis, though in fact it can attack adults, and it does not always cause paralysis. The virus which causes it has become much more widespread in recent years in the British Isles, and outbreaks of this disease have appeared without fail each summer and autumn in sufficient numbers to attract attention since 1947. The mode of infection and subsequent spread of the disease is difficult to trace, and it is common to meet isolated cases where there is no obvious source of infection, and the disease does not spread any further. Infection is probably spread by droplets from the nose, mouth and throat and probably also from the bowel Because of its morbid " news value " the disease has received a good deal of publicity in national and local newspapers, and the general public, especially the parents of young children have become very " polio " conscious. Unfortunately this gives rise to a good deal of unreasonable anxiety, amounting in some cases to panic, and the occurrence of a case of poliomyelitis is almost always accompanied by rumour and speculation which bears little relation to the true state of affairs. There is great need to take a balanced and reasonable view of this disease, so that parents may be spared undue distress and worry. Although the disease is notorious for the paralysis it can and does cause, about 25%—30% of the cases notified in 1950 throughout the country did not suffer from paralysis. Again during 1947 when poliomyelitis was present in this country in epidemic form, there were 688 deaths from this disease, whereas tuberculosis caused 23,075 deaths and 4071 persons were killed in traffic accidents. Thus whilst poliomyelitis is a serious disease, it is important that we keep it in its proper perspective in relation to other hazards to life, and limb. As far as Health Area No. VII was concerned the incidence of poliomyelitis during 1950 was considerably above that for the two previous years. In all 14 cases were notified of which 10 were accompanied by paralysis, while in four there was no paralysis. There were no deaths from this disease. The case rate per 1000 of the population was 0.27 as against a rate of 0.18 for England and Wales as a whole.

Of the other infectious diseases notified during 1950 whooping cough and pneumonia were most numerous. With pneumonia, erysipelas and meningitis the local case rates were above the national figure, whilst with measles, whooping cough, scarlet fever and puerperal pyrexia the local case rates were better than those for England and Wales.

In my report for 1949 I referred to the supremely important part played by housing in the national economy. The demand for new houses continues unabated, and everywhere the claims of eager applicants outnumber the new dwellings which can be made available. The only factor which puts any curb on the apparently insatiable demand for new houses, is the relatively high rent which now attaches to new houses. This is the inevitable result of increased costs of wages and materials operating in the building industry. As far as housing is concerned it is interesting to observe that the fulfilment

of the manual workers demand for higher renumeration, and increased leisure has reflected back so adversely on themselves, and their families when they require to be rehoused. Many relatively well-paid manual workers are now finding it difficult to meet the high rents which are due in part to the higher wages paid to their colleagues, in the building industry. As far as social welfare, and public health are concerned it is most unfortunate that these factors should operate against the rehousing of those who require it, but it is not a matter which can be easily remedied. National and local financial resources are strained to well nigh breaking point, and the provision of further subsidies for housing, food or indeed any other public service is almost out of the question. Nothing short of increased productivity, and the best possible use of scarce and expensive materials holds out any hope for rehousing those who most require it at a cost they can afford to pay. It is hardly necessary to remind you that the provision of good housing is dependent on the availability of ancillary services, with water supply in the forefront. The progress of housing schemes is made much more difficult by the absence of these services, a fact which many of the less progressive rural areas throughout the country are now discovering in the very hard, and very expensive post-war school of experience. Considering all the difficulties which surround the problem of providing an adequate number of new houses together with the requisite ancillary services, I consider that District Councils in this Area have all made very good efforts in this direction.

Water supplies in the Area are variable, ranging from piped supplies of pure water to indifferent and dangerously polluted supplies from shallow wells and springs. In all cases there is anxiety during the dry summer months concerning the quantity of water available, and with piped supplies restrictions on consumption are usually necessary. In the case of the smaller schemes in villages and hamlets there is sometimes complete failure of the supply and expensive and inadequate substitutes have to be provided. The Liskeard Rural District Council and the Liskeard Borough Council have embarked upon a joint scheme of considerable magnitude, which has as its object the provision of a pure supply of piped water to the whole of the Liskeard and Rural District, at present badly served in this respect. As with all undertakings of this description the progress of the work is frustrated and impeded by shortage of materials, and the ever present bogey of rising costs. It is also worth remembering that the demands of the defence programme and such measures as the National Health Service or the national income are so heavy, and pressing that Governments grants to aid local schemes and projects of water supply, and sewerage may be much less generous than had been anticipated. This will lay a correspondingly heavier burden on local finances, and it may well be found that comprehensive schemes of water supply and sewerage though necessary, and long overdue cannot be undertaken through lack of ability to meet the high cost of such schemes.

The standard of sewerage and sewage disposal is generally unsatisfactory throughout this Area. In only one of the larger urban communities is any attempt made to treat sewage before discharging it to a waterway, and

even here the plant used is obsolescent and unsatisfactory. In villages and hamlets in the rural parts of the Area arrangements for sewerage and sewage disposal are generally primitive, inadequate and unsatisfactory. It is true that where new houses are constructed efforts are made to improve the state of affairs, and provided such small sewage disposal plants are carefully and regularly maintained they are tolerably efficient. As with water supply schemes the planning and provision of larger sewerage schemes is delayed and discouraged by a multitude of difficulties, the greatest of which is the high cost of such schemes. No one is prepared to argue against the necessity for the provision of water and sewage disposal—indeed the modern citizen and rate-payer regards these services less and less as amenities and more and more as the bare and basic necessities of life, especially if he has come from districts where they have been provided. Whilst as an official primarily concerned with the prevention of disease and the promotion of health I must advise and even urge the provision of these services, nevertheless I must temper my enthusiasm with a sense of reality. Unfortunately the harsh and easily perceptible reality of the matter is our physical and financial inability to provide these services. In thinly populated rural areas the over-riding difficulty is one of finance, though shortage of labour, and materials and transport difficulties all contribute to the slow progress in solving these problems. During and since the war many city and town dwellers have come to rural areas to live. They have in most cases been appalled by the primitive conditions existing in many rural areas and some have been vociferous in their demands for those things which are the normal concomitants of life in a large community. Whilst we must never abate our efforts to improve living conditions in rural areas, we must recognise the formidable financial and physical obstacles which confront our endeavours in this direction, and we must never lose sight of the magnitude of these problems.

It is not perhaps generally understood that the social services, of which the public health service is one, are in effect purchasable commodities, and have to be paid for out of a fixed and limited national income. However much a private individual may wish to spend on the promotion and preservation of his health, the size of his income inevitably places some limit to the amount he may devote to this purpose. This is equally true in the national life, and limits the size and scope of any service, to that which the community can pay for. Many people seem to regard the scope and benefits of the National Health Service as limitless, and do in fact use the Service as though that were the case. That such is not the case, successive Chancellors of the Exchequer have made abundantly clear, and they have in fact endeavoured to fix a "ceiling" beyond which the cost of the National Health Service may not rise. This necessary restriction on the size of the national bill for health services, means that within the National Health Service the various interests which provide health schemes and services have to compete with one another for a share of the limited total available. In such competition there is danger that the popular clamour for one type of service may ensure for it a larger share of the available funds than its real merit may give it title to. whereas the claims of less obviously beneficial parts of the service may suffer. Personally I should

need a lot of convincing, that the satisfying of the gargantuan thirst of the British public for liquid medicine is more important than the eradication of tuberculosis, or that the wholesale provision of dentures is more valuable than the care of those to whom age or chronic illness has brought infirmity. Most thinking people will agree that the logical way to approach the question of health in the nation is to adopt the positive approach—to teach people to acquire and promote good health in themselves and their families, and to keep disease at bay by preventing it. Yet in the present National Health Service the main emphasis is on curing disease, with preventive services a very poor second, being allocated only 8% of the 450 million pounds which the National Health Service claims from the national income. However wrong this outlook may be it will be very hard to alter it, and I see little prospect of a more logical approach to this question of health being adopted for many years ahead. Nevertheless it is something for which we must all strive, in our endeavour to make the best possible use of our limited national resources.

In the foregoing preface which will be common to the six Annual Reports I am called upon to write, I have touched upon these aspects of public health, and social medicine which seems to me to be important and to merit comment. Most of what I have had to say is not original, and has been much more convincingly and skilfully put by my colleagues in other parts of the country. The opinions and judgements I have formed are therefore not altogether my own, though their application to the area in which I work, and live is my responsibility. Some who read this Report will not agree with the conclusions I have reached and the opinions I have formed. I can only hope that in stimulating them to disagree with me, I may also stimulate them to seek after the best means of attaining our common goal—the good health and happiness of the community. We must all contribute in greater or lesser measure to the modifying and moulding of our social services so that they yield the best results. The National Health Service is one of the most recent arrivals on the scene, and it is without doubt one of the greatest experiments in social welfare so far undertaken in the world. To really succeed it will require all the support encouragement and guidance that thinking people everywhere can give.

I cannot conclude without thanking all who have assisted and encouraged me during the year 1950 in my endeavours to improve the health of the public in this part of Cornwall. May I hope that this co-operation will be extended to me as long as I continue to serve in this Area.

I have the honour to be

Your Worship, Ladies and Gentlemen,

Your obedient Servant,

P. J. Fox,

Medical Officer of Health.

BOROUGH OF LISKEARD.

Area of Borough	2704 acres
Population (Registrar-General's Estimate) ...	4340
Number of Inhabited Houses	1250 (approx)
Rateable Value of Borough	£32,971
Sum represented by Penny Rate	£132-3-3

Vital Statistics for 1950.

	Male.	*Female.*	*Total.*
Live Births	31	23	54

	Liskeard M.B.	Health Area No. 7	England and Wales
Birth rate per 1000 of population ...	13.1	15.1	15.8

	Male.	*Female.*	*Total.*
Still Births	1	0	1

	Liskeard M.B.	Health Area No. 7	England and Wales
Stillbirth rate per 1000 of population	0.23	0.32	0.37

	Male.	*Female.*	*Total.*
Deaths	33	33	66

	Liskeard M.B.	Health Area No. 7	England and Wales
Death rate per 1000 of population...	10.5	13.7	11.6

Deaths attributed to Pregnancy, Childbirth and the Puerperal State

No deaths were registered under these heads.

Deaths of Infants under One Year of Age—

	Male.	*Female.*	*Total.*
All Causes	0	1	1

	Liskeard M.B.	Health Area No. 7	England and Wales
Infant Mortality Rate per 1000 live births	18.5	18.9	29.8

Deaths from Enteritis & Diarrhœa under Two Years of Age

	Male.	*Female.*	*Total.*
	0	1	1

	Liskeard M.B.	Health Area No.7	England and Wales
Mortality rate per 1000 live births	18.5	1.3	1.9

Principal Causes of Death at all Ages

Heart disease	32
Cancer (all sites)	8
Respiratory disease	7
Intra-cranial Vascular lesions ("Stroke")	6
Genito-Urinary disease	3
Circulatory disease	3
Tuberculosis	2
Accidents	2
Digestive disease	2

	Males.	*Females.*
Average Age at Death	70.57	70.65

The foregoing statistics show that conditions affecting the health of the community in Liskeard Borough were up to the average for the surrounding area, and the country as a whole. The birth rate was again below the national figure. The probable reason for this is the relative dearth of young adults in the population because of the absence of large business or industrial concerns in which they could find employment. The death rate is commendably low and the average age at death is high. It is unusual to find the average age at death of males so closely approaching that of females, since the latter are normally more long lived to the extent of two or three years. In the list of the principal causes of death, the only matter which calls for any comment is the undue prominence of heart disease as a cause, accounting as it does for almost 50% of the deaths which occurred during the year.

Infectious Disease. During the year 9 cases only of infectious disease were notified in Liskeard Borough—an exceptionally small total when compared with the 1949 figure of 162 and the 1948 total of 34. No serious infectious disease occurred during the year, and there were no deaths from infectious disease.

The following are details of actual numbers of cases and case rates for 1950 :—

		Case rates per 1000 of population		
Disease	**Cases Notified**	**Liskeard M.B.**	**Health Area No. 7**	**England & Wales**
Measles	3	0.69	0.44	8.39
Erysipelas	3	0.69	0.36	0.17
Whooping cough	1	0.23	3.13	3.60
Scarlet fever	1	0.23	0.84	1.50
Pneumonia	1	0.23	1.26	0.70

Tuberculosis. I cannot unfortunately report in the same favourable terms about the incidence of tuberculosis in the Borough during 1950, since the notification of 10 cases represents a very

sharp increase—to be precise a 100% increase—over the figures for 1948 and 1949. As far as our enquiries have gone there is no single circumstance or set of circumstances which can be held responsible for the increase, and I think that in 1950 we have in Liskeard struck an unlucky patch as far as tuberculosis is concerned. The following are details of cases, deaths, case rates, and mortality rates in respect of tuberculosis :—

	New Cases.		*Deaths.*	
Age Group.	*M.*	*F.*	*M.*	*F.*
0 — 1	—	—	—	—
1 — 5	—	—	—	—
5 — 15	2	1	—	—
15 — 45	2	4	—	1
45 — 65	—	—	1	—
65 and over	1	—	—	—

Rates per 1000 of population

	Liskeard M.B.	Health Area No. 7	England and Wales
New cases	2.30	1.01	not known
All cases	5.99	5.12	not known
Deaths	0.46	0.40	0.36

These tables show that tuberculosis had the heaviest impact on children and young adults, 90% of the new infections being in people between the ages of 5 and 45 years. At the end of the year there were 26 known cases of tuberculosis resident in the Borough, an increase of 4 over the number at the end of 1949. Of these 26 cases, 19 suffered from pulmonary tuberculosis and 7 from non-pulmonary tuberculosis.

National Assistance Act 1948. No action under Section 47 of this Act was called for during 1950.

Water Supply.

The excellent water supply which the Borough possesses provided an adequate supply of pure water throughout the year.

Sewerage and Sewage Disposal. The generally unsatisfactory state of affairs in respect of sewerage and disposal of sewage persisted throughout the year. The Ministry of Health are aware of this, and when the Consulting Engineers have produced a revised scheme, based on up to date costs and considerations there will be a Public Inquiry into the whole matter.

Food. Routine inspections of premises in which food is handled and served were carried out during the year and where necessary advice and assistance was given. With the appointment of Mr. Burch as Meat Inspector and Additional Sanitary Inspector it has

been possible to devote more attention to inspections of food shops, cafes and licensed premises, with the results shown in the report of the Sanitary Inspector, Mr. Hoar. It will be seen that many of these establishments fall short in one respect or another, a very common failing being the lack of hot water for washing hands. This state of affairs is not unexpected when it is considered that practically all business premises in Liskeard are housed in very old buildings. Nevertheless practically all could be improved in some respect and every effort must be made to impress on those engaged in handling and selling food and drink the duty they owe to the public in ensuring that everything possible is being done to promote cleanliness in handling food.

The appointment of Mr. Burch as Meat Inspector, has meant a very much more effective inspection of and control over meat produced at the Liskeard Abbatoir. This is particularly important for the following reasons :—

(1) Meat produced at the Liskeard Abbatoir is widely distributed over South East Cornwall.

(2) The premises used are inadequate for the amount of slaughtering which now takes place, and constant supervision is necessary to ensure that the best possible use is made of the limited facilities available.

(3) The number of unsound and diseased animals sent for slaughter is very considerable and thorough inspection of all meat is very necessary.

Representations were made to Ministry of Food Officials concerning the structural shortcomings of the present abbatoir, and though not prepared to undertake all the alterations and improvements suggested, they did agree to carry out certain improvements. As the Ministry of Food is particularly concerned with campaigns to ensure clean food, it is important that any installations such as abbatoirs, which they control or operate should be models of correct practice in the hygienic handling of food.

Routine sampling of Ice Cream was undertaken throughout the year, and wherever possible the sale of pre-packed Ice Cream was encouraged.

Food Poisoning. No cases of food poisoning were notified during 1950.

Clean Food Campaign. Although considerable time was spent in special inspections of premises dealing with food and drink, no formal clean food campaign was undertaken during 1950.

Factories Act 1937. Because of shortage of staff and pressure of more important work no inspections were carried out during 1950. The number and extent of premises coming within the provisions of this Act is not great in Liskeard.

Housing. The completion of 32 traditional houses and 8 Cornish unit houses during 1950 represents quite good progress in the drive to rehouse those whose living conditions are unsatisfactory. Liskeard is a town in which the number of old substandard dwellings is above the average, and for this reason there will be a need for a fairly intensive housing programme for many years to come. During the year I have stressed the necessity for considering demolition or closing orders on many of the old substandard dwellings from which families are being rehoused. I feel that if this policy is not followed such dwellings may gain a reputation as houses from which the Council is inclined to give priority in rehousing, and moreover it is known that such substandard dwellings are apt to attract the wrong type of family as tenants.

Report of the Sanitary Inspector. The report of the Sanitary Inspector Mr. E. J. Hoar, A.R.S.I., which follows sets out in greater detail many of the matters referred to in the latter sections of my report. The appointment of Mr. Burch as an additional Sanitary Inspector has been a great help to Mr. Hoar in carrying out the multitude of duties which devolve upon the Sanitary Inspector of the present day. I should like to take this opportunity of thanking Mr. Hoar and Mr. Burch for the assistance and co-operation they have at all times given me.

APPENDIX 1.

Incidence of and Mortality from Tuberculosis in Health Area No. 7--1950

Age Group	*New Cases*		*Deaths*	
	Male	*Female*	*Male*	*Female*
0 — 1	—	—	—	—
1 — 5	2	—	—	—
5 — 15	5	2	—	—
15 — 45	13	18	7	4
45 — 65	6	2	4	2
65 and over	3	2	3	1
Totals	29	24	14	7

	Male	*Female*
Case rate per 1000 of population	0.55	0.46
Mortality rate per 1000 of population	0.27	0.13

Case Rates and Mortality Rates per 1000 of Population by Sanitary Districts in Health Area No. VII — 1950.

	New Cases	*Total Cases as at 31-12-50*	*Deaths*
Liskeard M.B.	2.30	5.99	0.46
Liskeard R.D.	0.49	3.52	0.42
Looe U.D.	1.08	5.92	—
St. Germans R.D.	1.07	6.50	0.44
Saltash M.B.	0.92	5.68	0.66
Torpoint U.D.	1.15	3.45	0.14
Health Area No. VII Cornwall	1.01	5.12	0.40
England and Wales	Not known	Not known	0.36

Sanitary Inspector's Report, 1950.

Water Supply. The past year has not been one in which any improvement or extensions have been carried out and there still remain houses in the rural part of the Borough which are supplied with water from shallow wells or streams.

These wells and streams are not above suspicion in that they are subject to pollution from surface drainage.

Premises so supplied :	Hendra Bridge	5 houses
	Greenbank	1 house
	Maudlin	1 ,,
	Bodgara	1 ,,
	Looe Mills	5 houses
	Treworgey	1 house
	Highwood	1 ,,
	Lestitha	1 ,,
	Well Plain Lane	1 ,,
	Ladye Park	1 ,,
	Welltown	2 houses
	Mount Pleasant	2 ,,

The year has been an extremely wet one, and it has been found necessary to keep the chalk and alum plant operating the whole of the year, this has meant considerable increase in the amount of Chalk and Alum used. The cost of running the Filtration Plant has increased partly owing to the larger amount of chemicals used and increased cost of labour and materials, but total costs worked out at per gallon amount to only .0015 parts of a penny per gallon.

Tests made by the County Laboratory service have stated the water is satisfactory.

Samples of water are tested at least once each week for residual Chlorine after filtration and have varied between .15 and .2 parts per million.

Sewerage—Sewage Disposal. The Sewerage system is composed of various types of sewers, *i.e.* :—Stoneware pipes—Concrete tubes—(Oval, Tile and Brick) sewers, Masonary wall sewers, the main outfalls being situated at Gut Lane—Lanchard Lane, field adjoining Lamellion House and a field below Liskeard Viaduct.

In addition there are outfalls from houses at Trevecca, Clifton Terrace, Wadeland Terrace and Lynes Cottages also houses at Moorswater and Lodge Hill.

The known defective sewers are as follows:—

Brick Sewers :—Bay Tree Hill, Barras Street, Part of Dean Street.

Masonary Wall Sewers :—Part of Dean Street, part of Westbourne Lane, Pond Bridge Hill, Gut Lane, Barras Place.

Stoneware Pipes :—New Road in front of Dean Terrace.

Meat Inspection. The appointment of a Meat Inspector in October has ensured that all meat is inspected, the Inspector being at the Abbatoir during slaughtering is able to inspect all carcases.

Building. The premises having been constructed for purely local needs are too small to deal with the large number of animals dealt with during the summer and autumn.

Details of number of animals slaughtered and meat condemned.

	Cows	Other Cattle	Calves	Sheep	Pigs
Number of Animals slaughtered	667	1262	1379	4069	279
Condemnation from all Diseases other than Tuberculosis					
(a) Whole carcase	41	27	37	76	2
(b) Carcases of which some part or organ condemned	392	330	5	106	7
(c) Percentage of the number inspected affected with disease other than T.B.	64%	28%	3%	4½%	3¼%
Condemnations-Tuberculosis					
(a) Whole carcases	33	21	—	1	7
(b) Carcase from which some part or organ condemned	202	53	1	—	14
(c) Percentage of the number inspected affected with T.B.	35%	6%	—	—	7½%

Other Foods Condemned:

Frozen Meat ...	295	pounds
Cheese	23	,,
Tripe	95	,,
Tinned goods ...	108	tins

Ice Cream:

Number of Manufacturers	1
Number of Registered Retailers ...	17
Retailers selling loose Ice Cream ...	2
Retailers selling pre-packed Ice Cream	15

Number of samples taken	33
Grade I ...	20
,, II ...	9
,, III ...	4
,, IV ...	Nil

Clean Food Regulations. A complete survey has been made of all premises where food is prepared or handled, and the Council has made application for permission to adopt the Model Bye-laws for the handling and wrapping, etc. of Food.

Factories Act 1937. No inspections have been made during the year.

Shops Act. All shops handling food have been inspected, no action taken, the consideration of defects will arise under the Bye-laws relating to clean food.

Scavenging and Street Cleaning. The whole of the work is carried out by direct labour and the disposal of house refuse has not been such a nuisance as in previous years, it having been possible to obtain clean soil to carry out controlled tipping.

Milk Shops and Dairies. The number of retailers delivering milk :—

Tuberculin Tested	2
Pasteurised	1
Ungraded Milk	5

Rodent Control. The routine treatment of Sewers and the Refuse Dump has continued, but although the Council agreed to carry out treatment on dwelling houses free of cost to the occupier, very little use has been made of the offer.

It would however be more satisfactory if the Council obtained their own operator so as not to be dependent on another authority.

Housing Act, 1936-1949. The Council has appointed an additional Inspector to undertake the inspection of meat and when available to carry out inspection of houses of a rateable value of £20 and under.

The inspection of meat has taken the whole of the Inspector's time up to the end of the year, but arrangements have been made to commence a house to house inspection early in 1951.

Houses Inspected on receipt of complaint	9
Notices served under Section 11, - 1936	4
Offers made by Owners under Section 11, and accepted by Local Authority	2
Nº action after service of notice under Section 11	2
Notice served under Section 9	1
On report by Inspector on Army Huts, number of Families rehoused, premises demolished	2
No action taken by Local Authority on report of Sanitary Inspector	1
Owner closing premises on report of Sanitary Inspector	1

Post War Housing.

Houses completed in 1950 by Local Authority	32
Cornish Units „ „ „ „	8
Total permanent houses erected by Local Authority since 1945	67
Temporary Bungalows „ „ „ „ „	25
Licenses approved for erection of houses by private enterprise	8
Private enterprise houses completed	6
„ „ „ in course of construction ...	2

Squatter's Camp, Luxstowe.

The number of occupied huts at present date	6

Public Health Act, 1936. Complaints received :—

Defective drains, informal notice served ...	3	nuisances	abated
Nuisance caused by Flies	1	„	„
„ „ „ Fish-frying premises	1	„	„
„ „ „ Choked Sewers ...	2	„	„
„ „ „ Damp Walls	1	„	„
„ „ „ Dangerous Walls ...	2	„	„
„ „ „ Dirty Premises ...	1	„	„

Informal Report in respect of a dangerous and insanitary building used as a School Canteen. Result, premises no longer used as a canteen.

Notices served under Section 93. Public Health Act, 1936

Premises Damp 1